BEFORE THE BOARD OF MEDICAL EXAMINERS

OF THE STATE OF ARIZONA

In the Matter of: GARY W. HALL, M.D. Holder of Board License No. 12977 For the Practice of Medicine In the State of Arizona	Board Case File No. 12496 FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER

The above captioned matter was heard and discussed by the Arizona Board of Medical Examiners (hereafter "Board") on March 24 and May 20, 1999. Gary W. Hall, M.D. (hereafter "Respondent") with his counsel, Duane A. Olson, Attorney at Law, on the aforementioned date appeared voluntarily before the Board in the context of an informal interview proceeding,[1] pursuant to the authority vested in the Board by A.R.S. § 32-1451(G), for the purpose of reviewing and inquiring into the facts relevant to Board Investigative Case No. 12496. After due consideration of the facts and law applicable to this matter, the Board voted on May 20, 1999 to issue the following Findings of Fact, Conclusions of Law and Order, pursuant to statutory authority of the Board i.e., A.R.S. § 32-1451(G) and (I).

FINDINGS OF FACT

1. The Board of Medical Examiners of the State of Arizona is the duly constituted authority for the regulation and control of the practice of medicine in the State of Arizona, pursuant to A.R.S. § 32-1401, et seq.

[1] On May 12, 1999, House Bill 2487 was signed by Governor Hull and filed with Secretary of State Bayless. House Bill 2487 amended A.R.S. § 32-1451(G), in part, by renaming the "informal interview" to "formal interview". Section 24 of House Bill 2487 declares the act as an emergency measure and therefore effective immediately.

2. Respondent is the holder of Board License No. 12977 for the practice of medicine in the State of Arizona; and, Respondent limits his medical practice to the specialty of ophthalmology and related surgery of the eye.

3. The Board issued Findings of Fact, Conclusions of Law and Consent Agreement for Probation regarding Respondent which is dated January 19, 1996, and hereafter cited as "Probation Order". The aforementioned Probation Order established specific restrictions and conditions applicable to Respondent in his medical practice as an ophthalmologist. The Board's Probation Order placed Respondent on probation for a period of three years. The Board subsequently issued its First Amendment to Findings of Fact, Conclusions of Law and Consent Agreement for Probation dated February 3, 1997; however, said amended Order of the Board (dated February 3, 1997) is not relevant to the issues in dispute in the pending matter.

4. Pursuant to the Board's Probation Order at page 6, paragraph 1. (G), the Board was authorized to conduct quarterly reviews of Respondent's patient charts involving radial keratotomy and cataract surgery. Pursuant to the aforementioned terms of the Probation Order the Board's former executive director, Mark Speicher, requested Jack A. Aaron, M.D. to perform a review of medical records obtained at the office of the Respondent; and, said survey was conducted on December 9, 1996 and was limited to those patients treated by Respondent after the effective date of the Probation Order.

5. Jack A. Aaron, M.D., is a licensee of the Board and Diplomat of the American Board of Ophthamology who practiced primarily in Tucson, Arizona, at the time when the office survey of Respondent's medical records was conducted in 1996. The purpose of the survey was to review Respondent's patient records to determine if they were being maintained and patients were being treated in compliance with the terms of the Board's Probation Order.

As a result of conducting the office survey Dr. Aaron submitted a written report dated December 13, 1996. On the basis of the aforementioned report received from Dr. Aaron, the Board did not initiate any specific action alleging possible violations of the Board's Probation Order.

6. At the Board's public meeting on January 24, 1997, the Board reviewed Respondent's compliance with the Probation Order and considered his request for an extension of time to complete the Probation Order requirement that he perform 80 hours of community service within one year of the date of the Probation Order being issued. The Board voted to grant a three months extension of time to complete the 80 hours of community service; and, Board staff subsequently reported to the Board that this requirement was satisfied.

7. On or about February 9, 1998, Board staff initiated another patient charts review and obtained from the Respondent's office 30 patient charts that were selected at random; and, these patients were all treated by Respondent and received radial keratotomy ("RK") treatments subsequent to the effective date of the Probationary Order. The aforementioned 30 patient charts were then delivered to Robert W. Snyder, M.D., Ph.D., professor and head of Department of Ophthalmology, Health Sciences Center, University of Arizona. By letter dated July 9, 1998, Dr. Snyder reported on his findings and evaluation of Respondent's patient records. Specifically, Dr. Snyder addressed the issue of whether the patient records indicated that Respondent may have deviated from Board's Probationary Order concerning standards of practice and therefore the patient charts should be further reviewed by an out of state expert medical consultant. Based upon his review of the records, Dr. Snyder reported that there were 12 patient charts which merited further review by out of state medical consultant, with expertise in the field of ophthalmology and refractive surgery.

8. Based on the recommendation of Dr. Snyder, the Board's executive director retained the services of John Hofbauer, M.D., a physician licensed in the State of California specializing in ophthalmology and a specialist in refractive surgery and corneal transplant surgery.

9. Dr. Hofbauer was requested by the Board, through Dr. Richard Zonis, the Board's chief medical consultant, to evaluate and comment on the quality of care provided to the patients identified by Dr. Snyder and express an opinion on whether the RK procedures performed by Respondent were in compliance with the Probation Order requirement at paragraph 1(A), page 5, that Respondent:

> ". . . shall practice radial keratotomy (RK) within the guidelines of the "Practice Guidelines for Refractive Keratotamy" approved in May 1995 by the International Society of Refractive Surgery ("ISRS"). Additionally, for each RK performed by Dr. Hall, following the patient work up, Dr. Hall shall review the results of the pre-operative examinations with the patient and document that review appropriately."

10. Dr. Hofbauer subsequently delivered to the Board by letter dated November 4, 1998, a report on his evaluation of the twelve (12) patient records which are identified hereafter by initials to preserve the confidentiality of the patients' identity pursuant to the statutory requirement of A.R.S. § 32-1451.01(C).

L.S.	G.P.
M.Mc.	G.H.
E.L.	C.H.
F.C.	K.W.
V.S.	K.S.
J.B.	J.V.

11. Dr. Hofbauer later supplemented his initial written report with a letter, dated December 18, 1998, addressed to Dr. Zonis, the Board's chief medical consultant. Said letter from Dr. Hofbauer sets forth a supplemental explanation of the specific ways in which

Respondent performed RK procedures, for 11 of the 12 patients, in a manner which deviated from the ISRS Guidelines and explains the resulting adverse consequences for the patients.

12. On November 20, 1998, as part of the Board's public meeting agenda, the Board discussed the matter of Respondent's compliance or non-compliance with the terms and conditions of the Board's probationary Order. Furthermore, during the course of the aforementioned public meeting and discussion, the Board heard the opinions of the Board's Chief Medical Consultant Dr. Richard D. Zonis, and Dr. Hofbauer who made a detailed presentation of his findings regarding the 12 patient cases reviewed by him.

13. During the course of Dr. Hofbauer's appearance before the Board on November 20, 1998, he summarized his findings. Dr. Hofbauer expressed the opinion that all but one of the 12 patients cases reviewed by him were treated in a manner by the Respondent that constituted the practice of RK outside the ISRS Guidelines established by the Board's Probation Order.

14. Dr. Hofbauer reported to the Board that in regard to patient F.C. the Respondent's patient notes establish that the patient was told of a finding of an irregular cornea, which in the opinion of Dr. Hofbauer may be an indication of keratoconus. The clinical definition of keratoconus is unstable refraction, apical corneal thinning. In the opinion of Dr. Hofbauer performance of RK on this patient was outside the ISRS Guidelines.

15. In regard to patient F.C., Respondent deviated from the ISRS Guidelines by exceeding recommendations in the guidelines for no more than 16 radial incisions per eye. Instead, Respondent made a total of 23 incisions in one eye. In the opinion of Dr. Hofbauer patient F.C. will experience adverse results from the surgery. Specifically this type of patient would have substantial problems with light sensitivity resulting in what is called "starbursts." At night when the patient's pupils dilate there is a likelihood that the patient will see multiple

images; and, it would not be unusual for this type of patient to require a corneal transplant to try to alleviate the aforementioned side effects from this surgery. The patient records for F.C. indicated that the patient was complaining of a starburst effect at night. In the opinion of Dr. Hofbauer a patient with the level of myopia reported in the patient notes for F.C. may be treated with radial keratotomy but would typically receive only 8 radial incisions in a 3 mm optical zone.

16. Patient F.C., according to Dr. Hofbauer, had an optical zone which in one eye was measured at 2.25 mm and the other eye measured at 2.50 mm. In the opinion of Dr. Hofbauer, the ISRS guidelines provide that optical zones should not be below 2.75 mm.

17. Notwithstanding the fact that Respondent went outside of the ISRS Guidelines when he performed the aforementioned RK procedure for patient F.C., said deviation does not per se constitute a violation of the Board's Probationary Order, if Respondent complied with the Probation Order requirements at paragraphs 1 (C) and (D).

18. The Board finds that patient F.C. (a resident of Mesa, Arizona) had RK surgery performed by Respondent on the same day that patient F.C. signed the authorization for surgery (i.e., 3/1/96). The patient record for F.C. establishes that Dr. Hall did not personally conduct a pre-operative examination and have an informed consent discussion with F.C. as required by the Probationary Order at paragraph 1 (C).

19. Patient K.S. was at the time the operative procedure was performed a 35 year old woman with right eye refraction –3.25 and left eye –4.00. The patient underwent radial keratotomy and astigmatism surgery and was overcorrected. In other words the patient's eyesight went from being nearsighted to being farsighted which was due to Respondent's operative procedure causing the cornea of the patient's eye to flatten too much. Dr. Hofbauer reported that Respondent in an attempt to correct the astigmatism (which means that the cornea

was slightly oval in shape), made additional incisions which further flattened the cornea and made the farsightedness worse. In the opinion of Dr. Hofbauer, Respondent performed RK on patient K.S. in a manner that was outside the ISRS Guidelines. The use of RK to correct myopic astigmatism is recognized by the ISRS Guidelines, but not to correct hyperopic astigmatism. Therefore, the RK procedure performed by Respondent was outside the ISRS Guideline. When deviating from ISRS Guidelines, Respondent was required to comply with paragraphs 1 (C) and (D) of the Probationary Order. Respondent did not comply with the aforementioned requirement in that his patient records do no establish that he personally conducted a pre-operative patient examination and informed consent discussion with K.S. to the extent required in paragraph 1 (C). Additionally, the patient records do not document Respondent or another ophthalmologist conducting a post-operative visit with the patient, as required.

20. Patient J.B. underwent radial keratotomy and astigmatism surgery. Dr. Hofbauer reported that the patient records reflected that the patient was told that correcting astigmatism will correct hyperopia. Repeat surgery was performed on this patient. In the opinion of Dr. Hofbauer, the treatment of the patient's residual hyperoptic astigmatism with further astigmatic keratotomy was inappropriate and the statement that the procedure would correct hyperopia (farsightedness) was false. In the opinion of Dr. Hofbauer the performance of incisional surgery on a patient who is farsighted (for example, patients K.S. and J.B.) is inconsistent within the ISRS guidelines. The patient records fail to document that Respondent conducted the requisite pre-operative examination and informed consent discussion personally with Respondent required by Probationary Order, paragraph 1 (C).

21. Dr. Hofbauer expressed the opinion that patients L.S., J.V., V.S. and K.W. all had multiple astigmatic incisions. The ISRS guidelines discuss the use of single or paired

incisions, straight or arcuate of varying lengths. However, Respondent deviated from the aforementioned ISRS standards by using a technique employing multiple incisions and multiple pairs of incisions which are not within the ISRS guidelines. All of the aforementioned patients were treated by Respondent in conformity with the Board's Probationary Order, except patient J.V., whose patient records do not reflect that Respondent personally conducted the informed consent discussion with the patient or document compliance with the post-operative examination requirements of paragraph 1 (C) and (D).

22. In regards to patient G.P., M.Mc., G.H., E.L., K.W. and V.S., Dr. Hofbauer reported that these patients had augmentation procedures using no clearly defined optical zones. Respondent instead utilized his own unique procedure for defining the optical zones which Respondent references as "tactile optical zones." The ISRS guidelines discuss optical zones between 2.75 mm and 5.5 mm; and, the guidelines imply in the opinion of Dr. Hofbauer that the optical zones should be measured and clearly defined by the surgeon. In the opinion of Dr. Hofbauer, Respondent's reliance upon or use of "tactile optical zones" did not provide clear measurement of the patient's optical zone and therefore falls outside the requirements of the ISRS guidelines. Therefore, Respondent was obligated to comply with the requirements of Paragraph 1 (C) and (D) of the Board's Probationary Order when performing RK on these patients.

23. The Board's Probation Order at page 5, paragraph 1(C) reads as follows:

> That in cases where performing radial keratotomy would fall outside the ISRS Guidelines, Dr. Hall shall personally conduct a pre-operative examination and informed consent discussion with the patient on a different calendar day than the calendar day of the surgery, and Dr. Hall or another ophthalmologist shall conduct a post-operative examination on the patient. In the case of a patient coming in from out of town for radial keratotomy that falls outside the ISRS Guidelines, the pre-operative examination and informed consent discussions shall occur at least six (6) hours in advance of surgery, which may be

performed on the same day. In all cases referenced herein the patient shall sign a separate consent form as appropriate in addition to the regular six page consent form described in Paragraph B, above.

24. Review of the patient records for those patients identified previously herein at paragraph 10 discloses that, where Respondent performed RK procedures in a manner outside the guidelines of the ISRS, he failed to obtain a separate signed patient consent form that identifies the procedures being performed outside the guidelines of the ISRS. Said conduct constitutes a violation of the terms of the Probation Order at page 5, paragraph 1(C).

25. The Board's Chief Medical Consultant, Richard Zonis, M.D., reported to the Board that Respondent was not in compliance with that part of the Probation Order at paragraph 1(C) which states that "... in cases where performing radial keratotomy would fall outside the ISRS guidelines, Dr. Hall shall personally conduct a pre-operative examination and informed discussion with the patient on a different calendar day than the calendar day of surgery." Dr. Zonis reported that Respondent violated this term of the Probation Order in regard to patient F.C. whom Respondent saw the same day of surgery and patient M.Mc. who he saw the same day of surgery. Additionally, Dr. Zonis reported that his review of the patient records for F.C. disclosed that Respondent failed to comply with that part of the Probation Order at paragraph 1(C) that requires Respondent or another ophthalmologist to conduct another post-operative examination of the patient. Dr. Zonis reported that in regards to patients G.H. and E.L., the record reflects that these patients were post-operatively seen by an optometrist; but, the patient chart fails to document that the patient was seen by an ophthalmologist after surgery.

26. The Board's Probation Order at page 6, paragraph 1(D) reads as follows:

That in all cases where Dr. Hall will not be providing post-operative care to the patient, Dr. Hall shall inform the patient

of that fact in addition to informing the patient of who will be performing the post-operative care, and document it in the patient's chart.

27. Dr. Zonis reported to the Board that Respondent failed to comply with the above cited condition of the Probation Order at page 6, paragraph 1(D). Specifically, Dr. Zonis reported that of the 12 patient charts cited above at paragraph 10, there were seven (7) that were not seen post-operatively by Dr. Hall and two (2) (G.H. and E.L.) were seen post-operatively by an optometrist. Dr. Zonis reported additionally that four (4) of the aforementioned 12 patient records reflect that Dr. Hall's associates, i.e., Drs. Schoofs and Krischer saw the patients. However, there is no documentation in any of the patients' charts confirming as required that the patient was informed that Respondent would not be providing post-operative care to the patient. Dr. Zonis further reported that his review of patient records for G.P. disclosed that there was no documentation of post-operative physician follow-up treatment of the patient, who instead received treatment by an optometrist. The aforementioned conduct by Respondent also was a violation of paragraph 1 (D) of the Probation Order.

CONCLUSIONS OF LAW

1. The Board of Medical Examiners of the State of Arizona possess jurisdiction over the subject matter hereof and over Gary W. Hall, M.D., who holds Board license No. 12977 for the practice of medicine in the State of Arizona.

2. The Board has received substantial evidence supporting the Findings of Fact described above and said Findings of Fact at paragraphs 7 through 27 constitute unprofessional conduct or other grounds for the Board to take disciplinary action pursuant to the following statutory definition of unprofessional conduct:

A. A.R.S. § 32-1401(25)(a), violating any federal or state laws or rule and regulation applicable to the practice of medicine; and,

B. A.R.S. § 32-1401(25)(q), any conduct or practice which is or might be harmful or dangerous to the health of the patient or the public.

C. A.R.S. § 32-1401(25)(r), violating any formal order, probation, consent agreement of stipulation issued or entered into by the board or its executive director under the provisions of this chapter.

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, and pursuant to the authority granted to the Board by A.R.S. § 32-1451(G),

IT IS HEREBY ORDERED as follows:

1. Respondent is censured for unprofessional conduct as more specifically described in the above Conclusions of Law; and,

2. Respondent is permanently prohibited from performing radial keratotomy, including enhancements, from and after the effective date of this Order and regardless of whether the patient previously had radial keratotomy or is a new patient for Respondent; and,

3. Respondent is also placed on probation and ordered to comply with the following terms and conditions:

A. Respondent is prohibited from performing refractive surgery of all types from and after the effective date of this Order and said restriction of medical practice by Respondent shall be for a minimum period of one year; and,

B. As a condition precedent to termination of the aforementioned restriction in this paragraph 3(A), Respondent must demonstrate to the Board that he has taken and satisfactorily completed a thirty (30) days mini-residency in refractive

surgery and fifty (50) hours of continuing medical education ("CME") in refractive surgery, prior to the Board authorizing termination of this restriction. The aforementioned supplemental training and CME shall first be approved by Board staff (i.e., Board executive director or designee).

C. Respondent is directed to comply with staff's requests for patient charts for review (exclusive of RK patients) to critically evaluate the quality of ophthalmic care and surgery provided to patients by Respondent. Said patient chart review to include all aspects of Respondent's ophthalmic practice and surgical procedures. Said patient chart review to be limited to those patients receiving ophthalmic surgery by Respondent commencing from January 1, 1997, and continuing prospectively during this probationary period. The number of patient charts reviewed and the frequency of chart reviews to be determined by the Board's executive director or other Board staff as designated by the executive director.

D. The period of probation shall be for three (3) years, from the effective date of this Order; and,

E. Respondent is fined a total of $15,000 as a civil penalty, for the aforementioned violation of the Board's statutes defining unprofessional conduct; and Respondent shall pay said civil penalty entirely within sixty (60) days from the effective date of this Order; and,

F. Failure by Respondent to comply with the terms of probation shall constitute grounds for new disciplinary action by the Board, including but not limited to suspension or revocation of license; and,

G. Respondent shall comply with all Board statutory and administrative rule requirements applicable to a physician/licensee of the Board.

4. This Order is limited to administratively resolving and disposing of the Board's investigation of the issue of Respondent's violation of the Board's Probationary Order of January 19, 1996, to the extent previously identified in the above Findings of Fact and described in that Board's administrative record for informal interview proceedings beginning on March 24, 1999. This Order therefore is only intended to resolve those specific patient cases that were reviewed and referenced in the medical consultant reports submitted to the Board by John D. Hofbauer, M.D. and Robert W. Snyder, M.D. In the event that a new patient file or complaint is received by the Board or is currently under investigation by the Board alleging unprofessional conduct due to Radial Keratotomy procedure performed by Respondent, then said case(s) is excluded from resolution and final disposition, pursuant to the terms of this Order.

NOTICE

Respondent is hereby notified that he may file a motion for rehearing in this matter requesting reconsideration of the Board's decision, pursuant to A.R.S. § 41-1092.09(B), as amended. Said motion for rehearing must be filed with the Board's executive director within thirty (30) days after the service of this Order or the right to submit said motion is waived; and, service of this Order is effective five (5) days from date of mailing to Respondent. To obtain an Order from the Board granting the motion for rehearing and reconsideration, Respondent must also comply with the requirements of Board Administrative Rule, A.A.C. R4-16-102(C) and establish good cause for granting said motion. Respondent is hereby notified that a failure to file a motion for rehearing or review within thirty (30) days after service of the decision has the effect of prohibiting a party from seeking judicial review of the Board's decision, pursuant to A.R.S. § 12-901 et seq.

This Order shall become effective and in force upon the expiration of the aforementioned time period for Respondent to file a motion for rehearing with the Board. However, the timely filing of a motion for rehearing shall stay the enforcement of the Board's Order, pursuant to A.R.S. § 41-1062(B), unless the Board has expressly found good cause to believe that the Order shall be effective immediately upon issuance and has so stated in this Order.

ISSUED AND EFFECTIVE this 27 day of May, 1999.

BOARD OF MEDICAL EXAMINERS
FOR THE STATE OF ARIZONA

Tom Adams

CLAUDIA FOUTZ, Executive Director
TOM ADAMS, Assistant Director
1651 E. Morten, Suite 210
Phoenix, Arizona 85020

Original of the foregoing filed this 28th day of MAY, 1999, with:

Arizona State Board of Medical Examiners
1651 E. Morten, Suite 210
Phoenix, Arizona 85020

Copy sent this 28th day of MAY, 1999, by U.S. Certified Mail (Return Receipt Requested) to:

Gary W. Hall, M.D.
2501 N. 32nd Street
Phoenix, Arizona 85008

Copy of the foregoing mailed this 28th day of MAY, 1999, to:

Duane Olson
Attorney at Law
P.O. Box 47250
7243 North 16th Street
Phoenix, Arizona 85068-7250
(Attorney for Respondent)

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BEFORE THE BOARD OF MEDICAL EXAMINERS

IN THE STATE OF ARIZONA

In the Matter of **GARY W. HALL, M.D.** Holder of License No. **12977** For the Practice of Medicine In the State of Arizona.	Board Case No. 12496 **STIPULATION FOR CONSENT ORDER**

By mutual agreement and understanding, between the Arizona Board of Medical Examiners (hereafter "Board") and Gary W. Hall, M.D. (hereafter "Respondent"), the parties agree to the following disposition of this matter.

1. Respondent acknowledges that he has read this Stipulation and the attached stipulated Consent Order; and, he is aware of and understands the content of the documents.

2. Respondent understands that by entering into this Stipulation for issuance of the foregoing Consent Order, Respondent voluntarily relinquishes any rights to a hearing or judicial review in state or federal court on the matters of fact or law alleged in the Consent Order or to challenge this Stipulation and the Consent Order in its entirety as issued by the Board and waives any other cause of action related thereto or arising from said Board Order(s).

3. Respondent acknowledges and understands that this Stipulation and the Consent Order will not become effective until signed by the Board's Executive Director.

4. Respondent acknowledges and understands that the Findings of Fact and Conclusions of Law setforth in the Board's Order issued on May 27, 1999, remain unchanged and are incorporated by reference and made a part hereof.

5. The parties mutually understand and agree that the Consent Order and its terms were stated on the record of the Board's rehearing proceedings conducted on September 24, 1999, and accepted by each party; and, therefore following Consent Order formally memorializes the terms and conditions previously agreed to and accepted by the parties.

6. Respondent acknowledges and agrees that, upon signing this agreement, and returning this document (or a copy thereof) to the Board's Executive Director, Respondent may not revoke acceptance of the Stipulation and Consent Order or make any modifications to the document, although said Stipulation and Consent Order has not yet been accepted by the Board and issued by the Executive Director. Any modifications to this Stipulation and Consent Order are ineffective and void unless mutually approved by the parties.

7. Respondent further understands that this Stipulation and Consent Order, once approved and signed, shall constitute a

public record document which may be publicly disseminated as a formal action of the Board.

8. If any part of the Stipulation and Consent Order is later declared illegal or otherwise unenforceable, the remainder of the Consent Order in its entirety shall remain in force and in effect.

Reviewed and accepted this 13 day of October, 1999.

By: _____
GARY W. HALL, M.D.

Reviewed and approved as to form this 21st day of October, 1999.

By: _____
Duane A. Olson, Attorney at Law
(Counsel for Dr. Hall)

CONSENT ORDER

Based upon the Board's Findings of Fact and Conclusions of Law and pursuant to the authority granted to the Board by A.R.S. § 41-1092.07(F)(5) and § 32-1451, IT IS HEREBY ORDERED that:

1. Respondent is censured for unprofessional conduct as more specifically described in the above Conclusions of Law; and,

2. Respondent is permanently prohibited from performing radial keratotomy, including enhancements, from and after the effective date of this Order and regardless of whether the

patient previously had radial keratotomy or is a new patient for Respondent; and,

3. Respondent is also placed on probation and ordered to comply with the following terms and conditions:

A. Respondent is prohibited from performing LASIK surgery thirty (30) days after issuance of this Order and said restriction shall be effective until Respondent completes a comprehensive course in the LASIK procedure, i.e., specifically a two and one half days course (i.e., "LASIK for the General Ophthalmologist") offered by Casebeer Education Foundation ("CEF") including didactic instruction and clinical observation and training. Respondent shall promptly provide written documentation from CEF to the Board's executive director confirming full attendance and participation in the aforementioned LASIK course in its entirety before resuming the performance of LASIK operative procedures.

B. Respondent is directed to comply with staff's requests for patient charts for review (exclusive of RK patients) to critically evaluate the quality of ophthalmic care and surgery provided to patients by Respondent. Said patient chart review to including all aspects of Respondent's ophthalmic practice and surgical procedures. Said patient chart review to be limited to those patients receiving ophthalmic surgery by Respondent commencing from

January 1, 1997, and continuing prospectively during this probationary period. The number of patient charts reviewed and the frequency of chart reviews to be determined by the Board's executive director or other Board staff as designated by the executive director.

D. The period of probation shall be for three (3) years, from the effective date of this Order; and,

E. Respondent is fined a total of $15,000 as a civil penalty, for the aforementioned violation of the Board's statutes defining unprofessional conduct; and Respondent shall pay said civil penalty entirely within sixty (60) days from the effective date of this Order; and,

F. Failure by Respondent to comply with the terms of probation shall constitute grounds for new disciplinary action by the Board, including but not limited to suspension or revocation of license; and,

G. Respondent shall comply with all Board statutory and administrative rule requirements applicable to a physician/licensee of the Board.

4. This Order is limited to administratively resolving and disposing of the Board's investigation of the issue of Respondent's violation of the Board's Probationary Order of January 19, 1996, to the extent previously identified in the above Findings of Fact and described in that Board's administrative record for informal interview proceedings

beginning on March 24, 1999. This Order therefore is only intended to resolve those specific patient cases that were reviewed and referenced in the medical consultant reports submitted to the Board by John D. Hofbauer, M.D. and Robert W. Snyder, M.D. In the event that a new patient file or complaint is received by the Board or is currently under investigation by the Board alleging unprofessional conduct due to Radial Keratotomy procedure performed by Respondent, then said case(s) is excluded from resolution and final disposition, pursuant to the terms of this Order.

Issued and effective this 21st day of October, 1999.

BOARD OF MEDICAL EXAMINERS
OF THE STATE OF ARIZONA

[S E A L]

By Claudia Foutz
CLAUDIA FOUTZ
Executive Director
TOM ADAMS
Assistant Director - Regulation

COPY of the foregoing mailed by Certified Mail this 21st day of October, 1999 to:

Gary W. Hall, M.D.
2501 North 32nd Street
Phoenix, AZ 85008

Copy of the foregoing mailed this
21st day of October, 1999, to:

Duane A. Olson, Esq.
OLSON JANTSCH BAKKER & BLAKEY, P.A.
7243 N. 16th Street
P.O. Box 47250
Phoenix, AZ 85068-7250
Attorney for Dr. Hall

Copy of the foregoing hand delivered
This 21st day of October, 1999, to:

Michael Harrison, Assistant Attorney General
Arizona Board of Medical Examiners
1651 East Morten, Suite 210
Phoenix, AZ 85020

Board Operations